MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

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Contents

DME Rate Adjustment

Effective for dates of service on or after February 1, 2006, the reimbursement rate for HCPCS code E1238 (wheelchair, pediatric size, folding, adjustable, without seating system) will be adjusted as follows due to the allowance paid by Medicare:

Code	Purchase Rate	Monthly Rental Rate
E1238	$1,638.73	$163.87

This adjustment is in accordance with *Welfare and Institutions Code*, Section 14105.48.

The updated information is reflected on manual replacement page dura cd 19 (Part 2).

Medi-Cal Crossover Claim Reminder

Providers are reminded that when Medicare makes an adjustment on a previously paid Medicare claim, the resulting automatic crossover Medicare adjustment does not get processed by Medi-Cal. When a provider receives a Medicare adjustment, the Medicare claim for the adjusted amount must be submitted in hard copy form to Medi-Cal. Prior to submitting the adjusted Medicare claim, the provider must void the original Medicare payment, or the adjusted claim will be denied with Remittance Advice Details (RAD) code **010: This service is a duplicate of a previously paid claim.**

To receive correct reimbursement from Medi-Cal for a previously reimbursed Medicare crossover claim, providers may file either a *Claims Inquiry Form* (CIF) or an appeal.

For information about completing a CIF, refer to the *CIF Special Billing Instructions* section in the appropriate Part 2 manual. For information about appeals, refer to the *Appeal Form Completion* section in the appropriate Part 2 manual.

This information is reflected on manual replacement page cif sp 7 (Part 2).

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

New Sterilization Consent Form for Family PACT Providers Coming Soon

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of a California Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

The revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for the first quarter of 2006 are listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

January 23, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

March 20, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

For a map and directions to the DHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org** and click the appropriate date under "Orientation Sessions" and print out a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468.

Please see **Family PACT**, *page 3*

Family PACT *(continued)*

If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228). Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information regarding the Family PACT Program, please call 1-877-FAMPACT or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers now have the ability to submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through an approved third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF), which is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:
cif sp 7/8
dura cd 19/20
hcfa sub 1/2 *
reject cd pos 7/8 *

* Pages updated due to ongoing provider manual revisions.